DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G793	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C **10/25/2011**

NAME OF PROVIDER OR SUPPLIER **SPECTRUM COMMUNITY SERVICES OF INDIANA LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **113 SOUTH 325 EAST** **VALPARAISO, IN 46385**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for the investigation of complaint #IN00097497. Complaint #IN00097497- Unsubstantiated, due to lack of evidence. Dates of Survey: October 22, 24, and 25, 2011 Facility number: 012584 Provider number: 15G793 AIM number: 201018520 Surveyor: Tim Shebel, Medical Surveyor III-Team Leader Spectrum, Inc. was found to be in compliance with 42 CFR, part 483, subpart I, and 460 IAC 9 in regard to the investigation of complaint #IN00097497. Quality review 11/03/11 by Suzanne Williams, RN	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.